

## **Women's Health: Issues in Mental Health, Alcoholism, and Substance Abuse**

### **Introductory Remarks**

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#### **Synopsis** .....

*The American Medical Women's Association has chosen as one of its strategic goals for the next year,*

*and probably for a lot longer, preventing young women from smoking. Smoking is of great concern to all as the death rate from lung cancer among women sky-rockets to bypass even breast cancer.*

*In alcohol and drug abuse, women who abuse alcohol and other drugs face a greater social stigma than the male abuser of these substances. The higher incidence of depression among women adds to the likelihood of self-medication with alcohol and other drugs.*

*Reproductive and sexual dysfunctions are frequent in women who have alcohol, drug abuse, and mental health problems, and they are more vulnerable to rape and other forms of sexual exploitation. Sexual abuse and assault may also have played an integral part in their problems.*

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## **Women's Health: Issues in Mental Health, Alcoholism, and Drug Abuse**

### **Mental Health and Older Women**

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#### **Synopsis** .....

*The number of elderly women is growing in absolute numbers and in proportion to the U. S. population. Current epidemiologic research indicates that the most frequent psychiatric disorders among older women are phobias, severe cognitive impairment, dysthymia, and major depressive episode without grief. The rates of all of these disorders, except for cognitive impairment,*

*are lower for older than for younger women. The rates of psychiatric disorders in older women are higher than in older men, except for alcohol abuse-dependence, which is higher in men.*

*Depression is a common psychiatric problem in older women. The differential diagnosis includes other medical disorders, drug effects, normal grief, and early dementia. Older depressed women may present with physical complaints rather than complaints of depression, and thus be misdiagnosed. Treatment consists of psychotherapy, antidepressant medication, and activities to improve self-esteem.*

*Dementia affects 4 percent of elderly women over age 65, and 20 percent of those over age 85. The most common cause is Alzheimer's disease. Current research is focusing on abnormalities in the cholinergic system in the brain. A careful psychiatric evaluation may identify medical conditions, including depression, which can be treated and can lead to improvements in the patient's functioning.*

**T**HE FOCUS OF THIS PAPER is mental health issues for older women. Older women are of special interest because their numbers are growing rapidly in absolute numbers and as a percentage of the U.S. population. (1). In 1984 there were more than 28 million elderly citizens of both sexes, and they represented 11.9 percent of the population. This group is expected to grow to more than 64 million by the year 2030 and to account for as much as 21.2 percent of the population. In the group 65 years and older, women outnumber men by 1.4 to 1. Within the older age group, the fastest growing group is the "old-old," people 85 years and older. This group numbered 2.2 million in 1980 and is estimated to grow to 7.3 million by the year 2020. In this age group, women outnumber men 2 to 1.

In 1980, the National Institute of Mental Health funded a multisite community study of the prevalence of specific mental disorders (2). Data from this Epidemiologic Catchment Area Survey, which began to be published in 1984, give the most complete picture to date of the prevalence of mental disorders in persons of all ages including the elderly (3). The rates were reported separately for New Haven, Baltimore, and St. Louis. In this paper, these findings will be reviewed, and age and sex differences will be highlighted. After discussing these epidemiologic findings, I will discuss some specific issues in the diagnosis and management of the two most significant mental disorders of older women, depression and dementia.

### **The Epidemiology of Mental Disorders in Older Women**

The prevalence of DSM-III (4) affective disorders was reported separately for major depressive episodes without bereavement, bereavement, manic episodes, and dysthymia as well as an overall rate for any affective disorder. For any affective disorder the rate for older women ranged from 3.1 percent in Baltimore and St. Louis to 5.0 percent in New Haven. This was more than twice the rate for older men in New Haven and Baltimore and six times the rate for older men in St. Louis. Compared with younger women, the rate of any affective disorder among older women ranged from less than one-third to less than one-half the rate for women ages 25 to 44, the age-sex group with the highest rates of any affective disorder. Two other findings are worth noting. First, as expected, there was a higher rate of bereavement among older women compared with older men or younger women. Second, no manic

episodes were reported among older women or older men.

In contrast to the findings on affective disorders, the overall rates for alcohol abuse-dependence for men were four to eight times as high as for women of all ages. In the older age groups, there was virtually no alcohol or drug abuse-dependence detected among older women compared with rates of 3 to 4 percent of older men who had an alcohol problem. The rates for men ages 25 to 44 were three or four times higher than the rates for older men.

The only mental disorder for which the rates were higher for older than younger persons was cognitive impairment. Severe cognitive impairment was defined as a score of 17 or less on the Mini-Mental State Exam (5), and mild impairment was defined as a score of 18 through 23. For older women, the rate of severe cognitive impairment ranged from 3.6 percent in St. Louis to 4.8 percent in Baltimore. Not unexpectedly, this was three to five times the rate among women ages 45 to 64, and in the younger age groups there were minimal rates of severe cognitive impairment. With respect to mild cognitive impairment, the rates for older women ranged from 11.6 percent in St. Louis to 4.8 percent in Baltimore. The rates of mild cognitive impairment did not appear to be different for men and women, but the rate of severe cognitive impairment was somewhat higher among older men. Mild cognitive impairment was present in younger persons but at a much lower rate than in the elderly.

For older women overall, the four most frequent diagnoses were phobias, severe cognitive impairment, dysthymia, and major depressive episode without bereavement. In contrast, the four most frequent mental disorders in older men were severe cognitive impairment, phobias, alcohol abuse-dependence, and dysthymia. For women of all ages, phobias were the most frequent problem. For women ages 18 to 24, drug abuse-dependence was the second most common disorder, major depression was third, and alcohol abuse-dependence was fourth. For women ages 25 to 44 and ages 45 to 64, obsessive compulsive disorder was the fourth most frequent problem after phobias, major depression, and dysthymia.

### **Depression in Older Women**

In discussing depression in older women, it is important to distinguish between transient sadness or dysphoria and clinical depression. Epidemiologic studies have found a higher rate of dysphoria among older women than among younger subjects (6), but

as noted above, the rates of clinical depression that meet DSM-III criteria are actually lower for older than for younger women. It should not be assumed, therefore, that it is normal for an older woman to be depressed because she is widowed or physically ill. Despite the many losses that accompany old age in women, most cope quite well and do not become clinically depressed. In an older woman with depressive symptoms, a careful psychiatric evaluation is necessary to assess the degree and nature of the depression to see if specific clinical interventions are necessary.

In considering the prevalence of depression in older compared with younger women, recent studies have suggested that there is an important cohort effect. In a study of depressed patients who had presented to several psychiatric clinics, their relatives of all ages were also interviewed (7). Surprisingly, the relatives of depressed patients had a higher lifetime prevalence rate of depression the younger they were. The group born after 1950 had the highest lifetime rate of depression, and the group born before 1910 had the lowest rate. This finding has led to speculation that the effect may be due to social or cultural factors, such as changing lifestyles or the opportunities in life, which differ by the size of the birth cohort. Alternatively, there may be some ongoing biological or environmental change. Nevertheless, it does appear that depression, though a serious problem among the elderly, is more common in younger age groups. This result contrasts with the longstanding finding that the overall rate of successful suicides rises with age (8), which is due primarily to the high rate for elderly white men. For women, the peak of successful suicides is around age 40, and the rate of suicide attempts is higher among younger women.

In evaluating older women with depressive symptoms, the many systemic diseases that can cause fatigue, lack of interest, somatic complaints, and other symptoms of depression must be ruled out (9). These include anemia, hypothyroidism, malignancies, diabetes, infections, and so forth. A careful history and medical workup will usually uncover the underlying medical illness. In the case of carcinoma of the head of the pancreas, depression may be the presenting symptom, and the malignancy may not be discovered until metastases have appeared (10). A variety of central nervous system disorders (for example, tumors, subdural hematoma, and so forth) can present with depressive symptoms or full-blown depression. In most cases there is some localized finding which points to the correct diagnosis. Depression is a frequent accompaniment of Park-

inson's disease and can be especially difficult to treat (11).

In addition to these physical disorders, a full-blown depressive syndrome or specific symptoms that may be attributed to a depression can be caused by prescription medications. If a specific symptom is due to medication (for example, loss of appetite due to a nonsteroidal antiinflammatory drug), the specific symptom will disappear when the drug that caused the symptom is stopped. If a full-blown depression has occurred, the patient will usually require specific treatment in addition to stopping the drug. The drugs most often implicated in individual cases of depression are those used to treat hypertension by affecting the catecholamine neurotransmitters that is, reserpine, methyl dopa, propranolol, and so forth) or sedative-hypnotic drugs such as the benzodiazepines.

The clinical presentation of depression in an older woman may be somewhat atypical from that seen in younger patients. Rather than reporting feeling "depressed," the older woman (or man) may present with physical symptoms or complaints and may be irritable and suspicious. Sometimes the presenting symptoms may be delusions of poverty or guilt or a somatic delusion. These may, at first, seem like exaggerations of age-appropriate fears of reduced income, deeds left undone or unatoned for, or of possible physical illness. A careful history, however, will clarify the delusional nature of the patient's fears.

One other presentation specific to older patients is that of the apathetic patient who shows decreased cognitive ability, loses interest, is less able to take care of herself, and is agitated. In the past, this syndrome was sometimes referred to as "pseudodementia" (12), but it is now referred to as "the dementia syndrome of depression," reflecting the fact that the patient does meet the criteria for dementia even though depression is the cause and not structural brain disease (13). One study showed that patients who complain about their memory are actually more likely to be depressed than to be demented (14). Demented patients generally try to deny and to hide any problem. Often both diagnoses will coexist, so the clinician should look for treatable depression even in the presence of "true" dementia. Several years ago, the dexamethasone suppression test was touted as a specific marker for melancholia (15) and it was hoped that this simple biological test could distinguish dementia from depression. Unfortunately, later studies showed a high rate of nonsuppression or false-positives among older demented patients (16).

The usual treatments are as effective in older women as they are in younger women. These include psychotherapy, structured activities, antidepressants and, for severe or refractory cases, electroconvulsive treatments. Even though psychotherapy is effective, Medicare only covers 50 percent of outpatient psychiatric treatment up to \$250 per year. That benefit has remained unchanged since the enactment of Medicare more than 20 yrs. ago, when fees were half what they are today. Obviously, this limited benefit greatly impairs the ability of older women to obtain psychotherapeutic treatment for their depression or other psychiatric problems.

## Dementia

As noted previously, severe cognitive impairment affects about 4 percent of women over the age of 65. The prevalence continues to rise with advancing age so that by age 85, 20 percent of the population has severe cognitive deficit and other symptoms of dementia. At various times it was mistakenly thought that this cognitive decline was due to "senility" or normal aging. Research with healthy older subjects suggests that they have more difficulty than younger subjects with short-term memory tasks when asked to divide their attention or to reorganize the material presented. Memory for remote events is also impaired in the elderly compared with younger subjects, but recall and recognition of past events in the recent past remains quite high. Mild forgetfulness, especially for names, is a normal phenomenon and should not alarm the patient or the clinician.

Neuropathologic studies of the brains of demented patients have shown that 50 percent of the cases are due to senile dementia of the Alzheimer's type (SDAT), and another 20 percent are due to SDAT in combination with multi-infarct dementia. This latter cause of dementia reflects focal brain infarcts rather than the generalized arteriosclerosis or "hardening of the arteries" which used to be thought of as the major cause of dementia. The characteristic neuropathology of SDAT includes numerous senile plaques and neurofibrillary tangles spread throughout the brain. Researchers are trying to identify the abnormal proteins in the neurofibrillary tangles to attempt to elucidate the etiology of the disease or provide a marker which can be used for early detection.

There are various theories about the cause of SDAT (17). Trisomy-21, which is the chromosomal abnormality associated with Down's syndrome, will invariably lead to Alzheimer's type neuropathology if

the person lives to age 50. Other genetic studies have suggested that the prevalence of SDAT is somewhat higher in the first-degree relatives of SDAT patients than in the general population (18). Another theory popular several years ago was that aluminum caused the disease because experimentally it produced neurofibrillary tangles. More recent evidence has indicated, however, that the tangles caused by aluminum are chemically distinct from those in SDAT. Furthermore, aluminum is ubiquitous in the soil and water so that the entire population is exposed to its effects.

The most exciting finding in the last 10 years has been the discovery that a specific enzyme in the brain, choline acetyl transferase, is greatly reduced in patients with SDAT and not in age-matched controls or in patients with other dementing disorders (19). It was hoped that this finding would lead to replacement therapies similar to those which led to dramatic improvements in patients with Parkinson's disease when L-dopa was introduced. To date, studies using precursors of acetylcholine (choline or lecithin) have been disappointing. Somewhat more encouraging have been studies using physostigmine, a drug which inhibits the enzyme acetylcholinesterase and thereby allows more acetylcholine to be available to the post-synaptic neuron (20). While statistically significant changes have been shown with physostigmine, the changes are small and of little clinical significance. As we learn more about the neurochemistry of SDAT, we hope to eventually learn how to treat or prevent the disorder.

The evaluation of a patient with SDAT should include a careful differential diagnosis as well as the identification of potentially treatable medical, psychiatric, or behavioral symptoms (21). Even if the patient has a "true" dementia, there will often be some benefit from treating these symptoms (22). Families also need help in dealing with specific symptoms and understanding what to expect as the disease progresses. Professional assistance as well as support from groups affiliated with the Alzheimer's Disease and Related Disorders Association are often helpful to families.

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## Women's Health: Issues in Mental Health, Alcoholism, and Substance Abuse

### Alcoholism and Women's Health

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#### Synopsis .....

*There are a variety of reasons why women are believed to be more susceptible than men to the effects of alcohol. Physical factors, such as body water content and hereditary predisposition to alcoholism, differentiate women from men. Social factors include secretive drinking, role model in the family, and a perceived increase in promiscuity. Societal stigmas make it difficult for alcoholic women to seek help, yet the mortality rates are high for those women who continue to drink.*

**I**N ANCIENT ROME, the use of alcohol by women was forbidden. Women were put to death by stoning or starvation for the offense of having been caught drinking. Perhaps the most interesting thing about Roman law was that the prohibition on women's drinking was written in the same sentence as the prohibition on adultery by women. There has been an association in the Western mind between women

who drink to excess and women who are sexually dangerous, lascivious, or promiscuous, a term which seems to be applied mainly to women and perhaps to men only to describe homosexual activities.

There has always been interest in women and alcohol. In 1798, Emmanuel Kant, the German philosopher, wrote about alcoholism in women, which he compared to alcoholism in Jews. Both groups, he